Panhandle Health District

Name_____ **FAMILY PLANNING HISTORY**

A. REVIEW OF SYSTEMS:		
YES	NO	GENERAL
		1. My health is generally good
		2. Night sweats/hot flashes
		3. Cancer. If yes, where/when?
		4. Smoke cigarettes. If yes, how many per day?
		5. Alcohol use. If yes, how many drinks/week?
		6. Birth defects or genetic problems
		7. Are you being treated for any illness/condition now? If yes what?
		8. Do you currently take medicine: ☐ prescription ☐over the counter ☐herbal? If yes, name:
		EYES
		10. Eye problems (except glasses or contacts)
		EARS/NOSE/MOUTH/THROAT
		11. Hearing problems
		12. Frequent nosebleeds
		13. Frequent sore throat (more than 6 per year)
		CARDIOVASCULAR
		14. Mitral Valve Prolapse
		15. Heart murmur
		16. Varicose veins
		17. Blood clots (head/leg/lungs)
		18. Stroke or stroke-like problems
		19. High blood pressure
		20. High Cholesterol
		RESPIRATORY
		21. Chronic cough or other breathing problems/asthma
		22. Tuberculosis or exposure to tuberculosis
		GASTROINTESTINAL
		23. Stomach or bowel problems
		24. Liver problems (hepatitis or tumor, etc.)
		25. Gallbladder problems
		GENITOURINARY
		26. Bladder or kidney problems
		27. Uterine fibroids
		28. Ovarian cysts
		29. Breast lump or discharge
		30. Last Mammogram (Breast X-Ray) Date: _____
		31. Vaginal discharge that itches/burns or has a bad odor
		32. Endometriosis
		33. Pain with sex
		34. Previous abnormal pap
		35 Last PAP Date: _____
		36. Did your mother take DES when she was pregnant with you?
		37. History of sexually transmitted infection. Check type: ❑chlamydia ❑gonorrhea ❑genital warts ❑herpes ❑syphilis ❑PID ❑ Hepatitis B ❑ HIV ❑ Other
		38. Your age at first vaginal intercourse. **AGE:** _____
		MUSCULOSKELETAL
		39 Arthritis or osteoporosis
		SKIN
		40. Acne or other skin problems. What?
		NEUROLOGICAL
		41. Migraine headaches (diagnosed by Clinician)
		42. Seizures/epilepsy
		43. Numbness in arms/legs (recurring)
		PSYCHOLOGICAL
		44. Depression - requiring treatment
		45. Suicide thoughts &/or plans?

A. REVIEW OF SYSTEMS (cont.)		
YES	NO	ENDOCRINE
		46. Thyroid problems
		47. Diabetes
		HEMATOLOGICAL/LYMPHATIC
		48. Anemia
		49. Sickle cell disease/trait
		50. Blood clotting disorder
		ALLERGY/IMMUNOLOGY
		51. Ever had Rubella (German measles)
		52. Ever had shot for Rubella? (German measles)
		53. Ever had a Tetanus shot?. Date?
		54. Ever had a Hepatitis B shot series? Date?
		55. Are you **allergic** to any drug, medication, latex or other substance, including local anesthesia? **If yes, what**?

B. HOSPITALIZATION AND SURGERIES	
Year	Reason

C. FAMILY HISTORY

Are you adopted? ☐Yes ☐No

Have your family **(parents, brothers, sisters)** had any of the following?

YES	NO	Diagnosis	Relative
		Osteoporosis	
		Diabetes	
		Heart attack/stroke before age 50	
		High blood cholesterol or fats	
		Genetic problems	
		Blood clots	
		Cancer: If yes, type:	
		High blood pressure	

STAFF COMMENTS / EXPLANATIONS (by number)

Label #5

D. PREGNANCY HISTORY

# of Pregnancies:	# of Miscarriages:
# of Live Births:	# of Still Births:
# of Living Children:	# of Abortions:
# of tubal Pregnancies:	☐ Never Pregnant
Date of Last Pregnancy:	
Do you plan to have children in the future? ☐Yes ☐No	

E. CONTRACEPTIVE HISTORY

Current birth control method:

How long used?:

Any problems with this method? ☐Yes ☐No

If yes, What?:

What method do you want to use now?

WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST:

YES	NO	METHOD	COMMENTS/PROBLEMS
		Abstinence	
		☐ Tubal ☐ Vasectomy ☐ Hysterectomy	
		Oral Contraceptives	
		Norplant	
		Depo-Provera (Injection)	
		Lunelle (injection)	
		IUD	
		Condoms (% of time used)	
		☐ Diaphragm ☐ Cap	
		Sponge	
		Patch	
		Ring	
		☐ Rhythm ☐ NFP	
		Withdrawal	

F. SOCIAL HISTORY

YES	NO	HAVE YOU RECENTLY EXPERIENCED:	COMMENTS
		☐ Emotional ☐ Relationship problems	
		☐ Job loss ☐ Financial problems	
		Problems in ☐ living arrangements ☐ school	
		☐ Legal problems ☐ Arrests ☐ Divorce	
		Parental problems	
		Are you physically abused?	
		Has anyone forced you to have sex?	
		Are you being sexually abused?	
		Have you been sexually abused in the past?	
		Are you afraid of your ☐ partner ☐ family member?	
		Are you currently safe?	

COMMENTS

G. MENSTRUAL HISTORY

1. Age periods began:
2. Number of pads/tampons used on heaviest day:
3. Length of period: (days)
4. Are your periods usually regular? ☐Yes ☐No
5. Last period started on: _____
   It seemed: ☐normal ☐ not normal
6. Do you experience, before or with periods: ☐cramps ☐bloating ☐bowel problems ☐emotional changes
7. Do you have vaginal bleeding after sex? ☐Yes ☐No
8. Do you have vaginal bleeding between menstrual periods: ☐Yes ☐No

H. STI/HIV RISKS

Number of sex partners in lifetime: MALE: FEMALE:

How many sex partners have you had during the past year?

YES	NO		COMMENTS
		Have you ever used street drugs? If Yes, when and what kind?	
		Have you received blood or blood products before 1985?	
		Did any partner: ☐ use needle drugs? ☐ have Hemophilia? ☐ have HIV / AIDS? ☐ have multiple partners? ☐ have partners of both sexes?	
		Have you shared needles? Example: Injecting drugs, tattooing, piercing?	
		Have you exchanged sex for drugs or money?	
		Have you been tested for HIV? When:_____	

Comments:

To the best of my knowledge the information I have provided is correct and complete

_____
Client Signature Date

_____
Staff Signatura Date

LABEL # 5 Here